Letters to the Journal

Letters are welcomed and will be published as space permits. Like other material submitted for publication, they should be typewritten, double-spaced, should be of reasonable length, and will be subject to the usual editing. The accuracy of statements of fact contained in these letters is the responsibility of the correspondent.

Views expressed in Letters to the Journal are those of the writers concerned and are NOT to be interpreted as the opinions of The Canadian Medical Association or of the editors.

CURRENT DRUG THERAPY

To the Editor:

I feel that the recent article "Drugs for Insomnia" under the heading of Current Drug Therapy (*Canad. Med. Ass. J.*, 89: 1331, 1963) should not be accepted in a scientific journal without comment. Whereas we as doctors are willing to accept opinions of our learned colleagues, I think in an article such as this the authors should take steps to point out that it is "their experience" or "their opinion" that such and such a drug is the one of choice. For example, I doubt if all practitioners would find that phenobarbital, 1 grain, is "the best drug to use" as a long-acting hypnotic. Phenobarbital is an anticonvulsive drug and, as I have been taught, its use is best restricted to such a purpose. Apart from being retained for as long as 72 hr. in the body, it is about the least predictable in its effects, and is often, if used over a period, cumulative and very depressive. Diphenhydramine hydrochloride (Benadryl) and promethazine (Phenergan) are both antihistamine drugs with a side effect of drowsiness. I would hardly consider it scientific medicine to depend on a drug's side effects for a therapeutic response.

Again, a dogmatic statement such as "In delirious or confused patients intramuscular paraldehyde is the best drug to use" should not escape comment. Who says it is the best drug? Perhaps it is, in some cases, but a word of caution surely about the painfulness of the injection is not irrelevant. Any doctor using the suggested dose of 5 c.c. intramuscularly will be very lucky to produce anything other than an increase in the confusion and/or delirium. At least 10 c.c. given in two separate sites may be effective.

I feel that the whole article, while containing information which is pertinent and useful (to a point) to a medical student, has little to offer the average general practitioner and is of a scientific standard well below that which one should expect of *The Canadian Medical Association Journal.*

T. H. ALMOND, M.D.
Wadena, Sask.

Dr. Almond's letter was referred to Dr. D. K. Ford, Chairman of the Editorial Subcommittee of the C.M.A. Committee on Pharmacy, sponsors of the series, and to the authors. Their replies are as follows:

To the Editor:

The articles on drug therapy are written by individual physicians who express personal opinions in the discussion of specific drugs. No more is being attempted than the presentation of a conservative, balanced, individual viewpoint on current drug therapy. It is recognized that the views expressed in such articles will not meet with universal agreement among medical readers. It was decided that short didactic articles would be presented although such articles often would not cover the subject fully. Such publications as the *Medical Letter*, medical journals and special monographs give a more complete account of the subjects discussed in this series—but it is hoped that short presentations will have some value, if only that of encouraging animated discussion. The members of the Editorial Subcommittee of the Committee on Pharmacy are grateful to Dr. Almond for his interest and hope that other readers will favour them with opinions concerning the series "Current Drug Therapy".

DENYS K. FORD, M.D.
Department of Medicine,
Vancouver General Hospital,
Vancouver, B.C.

To the Editor:

A short didactic article will nearly always show deficiencies, and we agree with Dr. Almond that it should be made known that our own opinions were being expressed. We had thought this implicit in the wording and are sorry that this was not the case.

As regards choice of drugs, however, we are loth to accept his criticisms. These drugs are used because we have found them best for our purpose, and we incline to the view that the anticonvulsant action of phenobarbital and the antihistamine effect of diphenhydramine hydrochloride (Benadryl) and promethazine (Phenergan) are not relevant. We agree that paraldehyde is sometimes given in large doses but cannot remember having used more than 5 c.c. at a time during the past six years. Often we may give a further dose a few hours later, and it seems more useful to control sedation in this way than to give a large initial dose.

D. P. JONES, M.D., F.R.C.P.[C]
and E. A. JONES, M.D.
750 West Broadway,
Vancouver, B.C.

TRANYLCYPROMINE CEPHALGIA

To the Editor:

In the article entitled "Tranylcypromine Cephalgia" by Drs. A. M. Mann and W. A. R. Laing, which appeared in the November 30 issue (*Canad. Med. Ass. J.*, 89: 1115, 1963), physicians are warned about the possible serious side effects of the use of tranylcypromine with and without methamphetamines. I would like to cite a case which probably implies that such precautions should extend even further.

A 40-year-old married woman was admitted to the Allan Memorial Institute, Montreal, because of depression. Clinical examination was within normal limits, and although her blood pressure was 140/90 mm. Hg on the day of admission, it remained in the vicinity of 120/80 throughout the rest of her hospital stay. Routine hematology and biochemistry were also within normal limits. Radiological studies revealed the presence of gallstones and a small hiatus hernia.

Four days after admission she was placed on tranylcypromine therapy, 10 mg. twice daily. Five days later